HR 2810

SGR Repeal and Medicare Beneficiary Access Act of 2013

Congress: 113 (2013–2015, Ended)
Chamber: House
Policy Area: Health
Introduced: Jul 24, 2013
Current Status: Placed on the Union Calendar, Calendar No. 283.
Latest Action: Placed on the Union Calendar, Calendar No. 283. (Mar 14, 2014)
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Sponsor

Name: Rep. Burgess, Michael C. [R-TX-26]
Party: Republican • **State:** TX • **Chamber:** House

Cosponsors (57 total)

Cosponsor	Party / State	Role	Date Joined
Rep. Dingell, John D. [D-MI-12]	D · MI		Jul 24, 2013
Rep. Pallone, Frank, Jr. [D-NJ-6]	D · NJ		Jul 24, 2013
Rep. Pitts, Joseph R. [R-PA-16]	R · PA		Jul 24, 2013
Rep. Upton, Fred [R-MI-6]	R · MI		Jul 24, 2013
Rep. Waxman, Henry A. [D-CA-33]	D · CA		Jul 24, 2013
Del. Christensen, Donna M. [D-VI-At Large]	D · VI		Jul 30, 2013
Rep. Benishek, Dan [R-MI-1]	R · MI		Jul 30, 2013
Rep. Bucshon, Larry [R-IN-8]	R · IN		Jul 30, 2013
Rep. Cassidy, Bill [R-LA-6]	R · LA		Jul 30, 2013
Rep. Castor, Kathy [D-FL-14]	D · FL		Jul 30, 2013
Rep. Cuellar, Henry [D-TX-28]	D · TX		Jul 30, 2013
Rep. Ellmers, Renee L. [R-NC-2]	R · NC		Jul 30, 2013
Rep. Engel, Eliot L. [D-NY-16]	D · NY		Jul 30, 2013
Rep. Gingrey, Phil [R-GA-11]	R · GA		Jul 30, 2013
Rep. Gosar, Paul A. [R-AZ-4]	R · AZ		Jul 30, 2013
Rep. Green, Gene [D-TX-29]	D · TX		Jul 30, 2013
Rep. Matsui, Doris O. [D-CA-6]	D · CA		Jul 30, 2013
Rep. Murphy, Tim [R-PA-18]	R · PA		Jul 30, 2013
Rep. Olson, Pete [R-TX-22]	R · TX		Jul 30, 2013
Rep. Sessions, Pete [R-TX-32]	R · TX		Jul 30, 2013
Rep. Stockman, Steve [R-TX-36]	R · TX		Jul 30, 2013
Rep. Thornberry, Mac [R-TX-13]	R · TX		Jul 30, 2013
Rep. Young, Don [R-AK-At Large]	R · AK		Jul 30, 2013
Rep. Bilirakis, Gus M. [R-FL-12]	R · FL		Jul 31, 2013
Rep. Blackburn, Marsha [R-TN-7]	R · TN		Jul 31, 2013
Rep. Latta, Robert E. [R-OH-5]	R · OH		Jul 31, 2013
Rep. McMorris Rodgers, Cathy [R-WA-5]	R · WA		Jul 31, 2013
Rep. Roe, David P. [R-TN-1]	R · TN		Jul 31, 2013
Rep. Rogers, Mike J. [R-MI-8]	R · MI		Jul 31, 2013
Rep. Schakowsky, Janice D. [D-IL-9]	D · IL		Jul 31, 2013
Rep. Terry, Lee [R-NE-2]	R · NE		Jul 31, 2013
Rep. Walden, Greg [R-OR-2]	R · OR		Jul 31, 2013
Rep. Braley, Bruce L. [D-IA-1]	D · IA		Aug 1, 2013
Rep. Capps, Lois [D-CA-24]	D · CA		Aug 1, 2013
Rep. Carter, John R. [R-TX-31]	R · TX		Aug 1, 2013
Rep. Barton, Joe [R-TX-6]	R · TX		Aug 2, 2013
Rep. Holding, George [R-NC-13]	R · NC		Aug 2, 2013
Rep. Lance, Leonard [R-NJ-7]	R · NJ		Aug 2, 2013
Rep. Westmoreland, Lynn A. [R-GA-3]	R · GA		Aug 2, 2013
Rep. Whitfield, Ed [R-KY-1]	R · KY		Aug 2, 2013
Rep. Brooks, Susan W. [R-IN-5]	R · IN		Sep 18, 2013

Cosponsor	Party / State	Role	Date Joined
Rep. Latham, Tom [R-IA-3]	R · IA		Sep 18, 2013
Rep. Walberg, Tim [R-MI-7]	R · MI		Oct 11, 2013
Rep. Rice, Tom [R-SC-7]	R · SC		Oct 15, 2013
Rep. Loebsack, David [D-IA-2]	D · IA		Oct 23, 2013
Rep. Coffman, Mike [R-CO-6]	R · CO		Oct 28, 2013
Rep. Bera, Ami [D-CA-7]	D · CA		Oct 29, 2013
Rep. Ruiz, Raul [D-CA-36]	D · CA		Oct 30, 2013
Rep. McKinley, David B. [R-WV-1]	R · WV		Nov 15, 2013
Rep. Stivers, Steve [R-OH-15]	R · OH		Nov 15, 2013
Rep. Kennedy, Joseph P., III [D-MA-4]	D · MA		Nov 21, 2013
Rep. Lujan, Ben Ray [D-NM-3]	D · NM		Dec 9, 2013
Rep. Rush, Bobby L. [D-IL-1]	D · IL		Dec 9, 2013
Rep. Yoder, Kevin [R-KS-3]	R · KS		Dec 9, 2013
Rep. Marino, Tom [R-PA-10]	R · PA		Dec 12, 2013
Rep. McNerney, Jerry [D-CA-9]	D · CA		Dec 12, 2013
Rep. Langevin, James R. [D-RI-2]	D · RI		Jan 8, 2014

Committee Activity

Committee	Chamber	Activity	Date
Energy and Commerce Committee	House	Referred to	Jul 24, 2013
Judiciary Committee	House	Referred to	Sep 13, 2013
Ways and Means Committee	House	Reported By	Mar 14, 2014

Subjects & Policy Tags

Policy Area:

Health

Related Bills

Bill	Relationship	Last Action
113 HR 4418	Related bill	**Apr 11, 2014:** Referred to the Subcommittee on Health.
113 S 2157	Related bill	**Mar 26, 2014:** Read the second time. Placed on Senate Legislative Calendar under General Orders. Calendar No. 336.
113 HR 4015	Related bill	**Mar 24, 2014:** Received in the Senate.
113 S 2122	Related bill	**Mar 13, 2014:** Read the second time. Placed on Senate Legislative Calendar under General Orders. Calendar No. 330.
113 S 2110	Related bill	**Mar 12, 2014:** Read the second time. Placed on Senate Legislative Calendar under General Orders. Calendar No. 327.
113 S 1871	Related bill	**Jan 16, 2014:** By Senator Baucus from Committee on Finance filed written report. Report No. 113-135.
113 S 1769	Related bill	**Nov 21, 2013:** Read twice and referred to the Committee on the Judiciary.

Summary (as of Mar 14, 2014)

SGR Repeal and Medicare Beneficiary Access Act of 2013 - (Sec. 2) Amends part B (Supplementary Medical Insurance) of title XVIII (Medicare) of the Social Security Act (SSA) to: (1) end with 2013 the current formula for an update to the single conversion factor in the formula for payment for physicians' services, (2) end and remove sustainable growth rate (SGR) methodology from the determination of such annual conversion factors, (3) prescribe an update to the single conversion factor for 2014-2016 of 0.5%, (4) freeze the update to the single conversion factor at 0.00% for 2017-2023, and (5) establish for 2024 and subsequent years an update of 2% for health professionals participating in alternative payment models (APMs) and an update of 1% for all other health professionals.

Directs the Medicare Payment Advisory Commission (MEDPAC) to report to Congress on the relationship between: (1) physician and other health professional utilization and expenditures (and their rates of increase) on items and services for which Medicare payment is made, and (2) total utilization and expenditures (and the rate of increase of such utilization and expenditures) under Medicare parts A (Hospital Insurance), B, and D (Voluntary Prescription Drug Benefit Program).

Directs the Secretary of Health and Human Services (HHS) to establish a value-based performance (VBP) incentive program by consolidating (with certain revisions) the existing: (1) electronic health record (EHR) meaningful use incentive program, (2) quality reporting program, and (3) value-based payment program.

Requires VBP-eligible professionals (excluding most APM participants) to receive annual payment increases or decreases based on their performance.

Defines VBP-eligible professional as: (1) a physician, a physician assistant, nurse practitioner, clinical nurse specialist, and a certified registered nurse anesthetist during the VBP program's first two years, and (2) also other eligible professionals specified by the Secretary for succeeding years.

Excludes from treatment as a VBP eligible professional any eligible professional who is: (1) a qualifying APM participant; (2) a partial qualifying APM participant for the most recent period for which data are available and who, for the performance period with respect to that year, does not report on applicable measures and activities a VBP professional is required to report; or (3) does not exceed, for that performance period, a specified low-volume threshold measurement.

Qualifies for VBP incentive payments a partial qualifying APM participant who reports on applicable measures and activities a VBP professional is required to report.

Prescribes requirements for: (1) application of the VBP program to group practices; and (2) measures and activities under the performance categories of quality, resource use, clinical practice improvement, and meaningful use of EHR technology.

Requires the Secretary to: (1) establish performance standards for the VBP program, taking into account historical performance standards, improvement rates, and the opportunity for continued improvement; and (2) develop a methodology for assessing the total performance of each VBP eligible professional according to such standards with respect to applicable measures and activities for each performance category, leading to a composite performance score for each professional for each performance period.

Prescribes requirements for creation of a performance funding pool from which all VBP program incentives payments shall be made. Makes such a funding pool consist of the total amount of specified gradual reductions to the otherwise applicable physician fee schedule for the years 2017-2021 and following years.

Prescribes a formula for the calculation of VBP program incentive payments, beginning with 2017, subject to criteria for budget neutrality as well as a process for informal review of the calculation of an individual professional's VBP program incentive payment adjustment factor for a year.

Directs the Secretary to enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers, or regional health collaboratives) to offer guidance and assistance about performance categories or transition to an APM to MIPS-eligible professionals in practices of 15 or fewer professionals (with priority given to such practices located in rural areas, health professional shortage areas, medically underserved areas, and practices with low composite performance scores).

Requires the Secretary to make available to each VBP eligible professional timely (such as quarterly) confidential feedback and other information to improve performance.

Requires the Comptroller General (GAO) to: (1) evaluate the VBP program; and (2) report on the similarities and differences in the use of quality measures under the original Medicare fee-for-service program, the Medicare Advantage program under Medicare part C, and private payer arrangements, and make recommendations on how to reduce the administrative burden involved in applying such quality measures.

Prescribes incentive payments for participation in eligible APMs between 2017 and 2022, consisting of an additional 5% of the current-year payment amount for the covered professional services for the preceding year.

Directs the Secretary to study: (1) the applicability of federal fraud prevention laws to items and services furnished under Medicare for which payment is made under an APM, (2) aspects of such APMs that are vulnerable to fraudulent activity, and (3) the implication of waivers to such laws granted in support of such APMs.

Directs the Secretary to study: (1) the effect of individuals' socioeconomic status on quality and resource use outcome measures for individuals under the Medicare program, and (2) the impact of certain risk factors on such quality and resource use outcome measures.

Directs the Secretary, taking account of such studies, to: (1) estimate how an individual's health status and other risk factors affect quality and resource use outcome measures and, as feasible, to incorporate information from quality and resource use outcome measurement into the eligible professional VBP incentive program; and (2) account for other identified factors with an effect on quality and resource use outcome measures when determining payment adjustments under the VBP incentive program.

Directs the Secretary to develop and report to Congress on a strategic plan for collecting or otherwise assessing data on race and ethnicity for purposes of carrying out the eligible professional VBP incentive program.

Directs the Secretary to take certain steps, including development of care episode and patient condition groups as well as proposed classification codes, in order to involve the physician, practitioner, and other stakeholder communities in enhancing the infrastructure for resource use measurement for VBP, APM, and other purposes.

(Sec. 3) Directs the Secretary to develop and post on the Internet website of the Centers for Medicare and Medicaid Services (CMS) a draft plan as well as an operational plan, taking stakeholder comments on the draft plan into account, for the development of quality measures.

Directs the Secretary to enter into contracts or other arrangements with entities, which may include physician specialty societies and other practitioner organizations, for the purpose of developing, improving, updating, or expanding such

quality measures.

Requires the Secretary to transfer $15 million from the Federal Supplemental Medical Insurance Trust Fund to the CMS Program Management Account for each of FY2014-2018.

(Sec. 4) Requires the Secretary to: (1) establish one or more Healthcare Common Procedure Coding System (HCPCS) codes for chronic care management services for patients with chronic care needs, and (2) make payments for any such services furnished by an applicable provider.

(Sec. 5) Authorizes the Secretary to: (1) collect or obtain information from any eligible professional or any other source on the resources directly or indirectly related to furnishing services paid for under the Medicare fee schedule, and (2) use such information to determine relative values for those services.

Authorizes the Secretary to establish or adjust practice expense relative values using cost, charge, or other data from suppliers or service providers, including any such collected or obtained information.

Expands the list of codes the Secretary must examine to identify services that may be misvalued, including codes: (1) that account for the majority of spending under the physician fee schedule, (2) that have experienced a substantial change in the hospital length of stay or procedure time, (3) for which there is a significant difference in payment for the same service between different sites of service, (4) with high intra-service work per unit of time, (5) with high practice expense relative value units (RVUs), and (6) with high cost supplies.

Sets at 0.5% of the estimated amount of fee schedule expenditures in 2015-2018 the annual target (estimated net reduction in expenditures under the fee schedule) with respect to relative value adjustments for misvalued services.

Declares that, for fee schedules beginning with 2015, if the RVUs for a service for a year would otherwise be decreased by an estimated 20% or more as compared to the total RVUs for the previous year, the applicable adjustments in work, practice expense, and malpractice RVUs must be phased-in over a two-year period.

Directs GAO to study the processes used by the Relative Value Scale Update Committee (RUC) (of the American Medical Association) to make recommendations to the Secretary regarding relative values for specific services.

Requires the use on or after January 1, 2017, of metropolitan statistical areas (MSAs) as fee schedule areas in California, with all areas not included in an MSA to be treated as a single rest-of-state fee schedule area.

Prescribes a formula for the geographic index values applied to the physicians fee schedule for MSAs previously in the rest-of-payment locality or in locality 3.

(Sec. 6) Directs the Secretary to: (1) establish a program to promote the use of appropriate use criteria for certain advanced diagnostic imaging services furnished by ordering and furnishing professionals, and (2) specify applicable appropriate use criteria for imaging services from among appropriate use criteria developed or endorsed by national professional medical specialty societies or other entities.

Directs the Secretary to: (1) determine, on a periodic basis, outlier ordering professionals; (2) apply prior authorization for applicable imaging services ordered by an outlier ordering professional; (3) establish an appropriate use program for other Medicare part B services; and (4) make publicly available on the Physician Compare website specified information with respect to an eligible professional.

(Sec. 8) Expands the kinds (including standardized extracts) and uses of claims data available to qualified entities for quality improvement activities, including analysis of data for non-public uses as well as their provision or sale (subject to certain conditions) to physicians, other professionals, providers, medical societies, and hospital associations and certain other entities.

Directs the Secretary to provide Medicare claims data to requesting qualified clinical data registries to link it with clinical data and perform analyses and research to support quality improvement or patient safety.

Restricts access to claims data through a qualified data enclave only (a web-based portal or comparable mechanism) from which data cannot be extracted. Requires any data or analyses to have no individually identifiable data about a particular patient, with specified exceptions.

Requires any fees charged for making standardized extracts of claims data available to qualified entities to be deposited into the CMS Program Management Account (currently, into the Federal Supplementary Medical Insurance Trust Fund).

(Sec. 9) Permits continuing automatic extensions of a Medicare physician and practitioner election to opt-out of the Medicare physician payment system into private contracts.

Directs the Secretary to: (1) make publicly available through an appropriate publicly accessible website information on the number and characteristics of opt-out physicians and practitioners, and (2) establish a demonstration project to make sure that Medicare payments for services furnished by non-participating physicians to individuals entitled to benefits under part A or enrolled under part B are paid directly to such physicians.

Directs the Secretary to make recommendations to Congress to amend existing fraud and abuse law to permit gainsharing or similar arrangements between physicians and hospitals that improve care while reducing waste and increasing efficiency.

Declares it a national objective to achieve widespread and nationwide exchange of health information through interoperable certified EHR technology by December 31, 2019, as a consequence of a significant federal investment in the implementation of health information technology through the Medicare EHR incentive programs.

Directs the Secretary to study the feasibility of establishing a website to compare certified EHR technology products.

Requires a GAO study on the use of telehealth under federal programs.

Actions Timeline

- **Mar 14, 2014:** Reported (Amended) by the Committee on Ways and Means. H. Rept. 113-257, Part II.
- **Mar 14, 2014:** Placed on the Union Calendar, Calendar No. 283.
- **Jan 10, 2014:** House Committee on Ways and Means Granted an extension for further consideration ending not later than March 14, 2014.
- **Dec 12, 2013:** Committee Consideration and Mark-up Session Held.
- **Dec 12, 2013:** Ordered to be Reported in the Nature of a Substitute (Amended) by the Yeas and Nays: 39 - 0.
- **Dec 2, 2013:** House Committee on Ways and Means Granted an extension for further consideration ending not later than Jan. 10, 2014.
- **Nov 12, 2013:** Reported (Amended) by the Committee on Energy and Commerce. H. Rept. 113-257, Part I.
- **Nov 12, 2013:** Committee on Judiciary discharged.
- **Nov 12, 2013:** House Committee on Ways and Means Granted an extension for further consideration ending not later than Dec. 2, 2013.
- **Sep 13, 2013:** Referred to the Subcommittee on the Constitution and Civil Justice.
- **Jul 31, 2013:** Committee Consideration and Mark-up Session Held.
- **Jul 31, 2013:** Ordered to be Reported (Amended) by the Yeas and Nays: 51 - 0.
- **Jul 30, 2013:** Committee Consideration and Mark-up Session Held.
- **Jul 24, 2013:** Introduced in House
- **Jul 24, 2013:** Referred to the Committee on Energy and Commerce, and in addition to the Committees on Ways and Means, and the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.
- **Jul 24, 2013:** Referred to the Subcommittee on Health.